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AUTHOR Garvin, Bonnie
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ABSTRACT

Eighteen conversations between patients and nurses or physicians were videotaped to examine patterns that the interactants followed to maintain dominant or recessive roles. Physicians/nurses were viewed as the dominant interactants because of their greater control in the hospital setting whereas patients were viewed as the recessive interactants because of their lesser control and their dependence on others for resources necessary in the recovery process. Analysis of the conversations resulted in the following rules implicit in the relationship between a patient and a nurse or physician: (1) nurses/physicians talk first: (2) nurses/physicians select the first topic in the first utterance: (3) nurses/physicians ask questions, the recessive interactant answers questions: (4) when the nurse/physician asks about a topic, the patient is obliged to pursue the topic: (5) topics in dominant-recessive interactions have to do with personal information regarding the patient; (6) when the patient has answered the question, the nurse/physician can then ask the same or similar question: (7) the nurse/physician may ask a question and without waiting for a reply may ask a second question: (8) the nurse/physician may verbally evaluate or revise the answer or response of the patient in the next turn: (9) the nurse/physician proposes membership categories that are accepted by the patient: (10) the nurse/physician manages the timing of the episode by using bracket markers: (11) the nurse/physician may interrupt the patient's talk before a transition-relevance cue occurs: and (12) the nurse/physician initiates the closing of the episode. These rules demonstrate that patients do not control their own time and space in interactions with physicians and nurses. (HOD)

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RULES FOR CREATING HEALTH CARE RELATIONSHIPS THROUGH TALK

BY

Bonnie Garvin, R.N., Ph.D
Assistant Professor
The Ohio State University
School of Nursing
1585 Neil Avenue
Columbus, Ohio 43210
614-422-7078

1980

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Purpose

The purpose of this descriptive study was to examine the patterned regularities in the conversations of dominant-recessive dyads to make explicit the rules used by interactants to maintain and perpetuate the relationship as dominant-recessive. Questions addressed are 1) What are the characteristic behaviors of the dominant and recessive interactants in accomplishing greetings, questions, suggestions, topic selection and closings? 2) How does the participation of the dominant person differ from participation of the recessive person? and 3) What rules do the persons use to accomplish smooth and orderly conversation?

Theoretical Framework

The study is based on several assumptions that are consistent with phenomenology and its interpretation by communication scholars in ethnomethodological accounts of how language works to accomplish social organization in everyday conversation (Schutz, 1963; Turner, 1974). The first assumption is that members of a speaking community share background knowledge that is taken for granted and unquestioned about what is appropriate and inappropriate conversational behavior in the role relationship. Interactants use this knowledge in creating an interaction and to interpret or make sense out of the conversation (Goffman, 1967).

This knowledge which is reflected in patterns of behavior can be reconstructed by identifying rules that the interactants are using to coordinate their talk. The rules not only describe the regularities but also give meaning to the actions from the perspective of the communicators (Cicourel, 1972; Litton-Hawes, 1977; Watzlawick, Beavin, & Jackson, 1967; Labov, 1972).

Rules are evidenced in patterned sequences of utterances. Utterances that regularly go together are called adjacency pairs (Schegloff and Sacks, 1974) questions/answers; summons/answers; greeting/greeting; correction-invitation devices/confirmation or refusal; demand tickets/acceptance or refusal. Utterances are aimed toward accomplishing episodes which are fundamental units of utterances viewed as distinct wholes, distinguishable from other types of discourse and characterized by special rules of speech and nonverbal behavior (Nofsinger, 1977). Episodes investigated in this study are a patient in a hospital being visited by a physician or a nurse. The basic question addressed was how episodes are structured by dominant-recessive interactants.

Physicians and nurses are viewed as the dominant interactants because of their greater control in the hospital setting over surgery schedules, hospital resources and everyday routines as well as their greater knowledge in the health and disease process affecting patients (Parsons, 1966). Patients are viewed as the recessive interactants because

of their lesser control and their dependence on others for resources necessary in the recovery process (Peplau, 1952).

Data Source

The data were naturally occurring videotaped conversations of actual nurse-patient and physician-patient dyads. These videotapes were part of a federally funded study conducted by M. Jean Daubenmire (1977). Detailed transcripts of thirty six episodes were completed using an adaptation of the transcription system developed by Gail Jefferson. Interactions are comprised of two female patients with four female nurses and two male patients with six male physicians. Same sex dyads were chosen so that the rules used were based on the dominant-recessive relationship rather than sex. Interactions were limited to those occurring in the first twenty four hours after admission to the hospital.

Method

A grounded theory approach to data analysis was used. This method of conversational analysis took place in several steps: 1) patterns of sequential structure were described, 2) assumptions for the phenomenon were identified, 3) the rules that exemplified the patterns were constructed using the sequential characteristics and the assumptions identified, 4) the rules were tested on new transcripts; counter instances of rule conformity, if occurrent, were then explicated, 5) the rules were refined and examples from the transcripts were selected to illustrate the rules. The procedures reflect

an attempt to describe how interactants do the ongoing interpretive work in interactions. Validity exists in the extent to which the researcher describes what is actually going on in the interaction and not on statistical significance in this phase of the research.

Results and Discussion

Analysis of eighteen episodes resulted in the identification of thirteen rules of a dominant-recessive relationship. These rules were found operative in the remaining eighteen episodes not used in the rule development phase. The rules for opening the interaction will be presented first followed by those for the body of the interaction and the closing of the interaction.

Rule 1. The dominant interactant talks first.

In all of the development data episodes except one, the dominant interactant began the sequence of talk. Several forms of conversation initiation were found. Ritual greetings and summons/answer sequences started some conversations; however, in over half of the episodes a greeting was omitted and in its place the dominant interactant asked a question.

Rule 2. The dominant interactant selects the first topic in the first utterance.

An inquiry into the state or activity of the other or the statement of an activity to be performed was made as in the following first utterances of episodes:

(1)	MDS 1	You goin back to bed or do you want to wait for awhile for your dad to come
	PT 2	°(I don't care)
(2)	MDS 4	How's the tube-? work
	PT 6	Well i it's func:tioning alright...
(3)	RN 5	Did they? ta:?lk to you yet about your surgery
	PT 5	No:

In each instance, the patients appropriately answer the questions posed and assume an open state of talk.

The ommission of greetings and SA pairs indicated several assumptions about the initiation of interaction. First, the recessive interactant was available for talk and a greeting or summons was not necessary to establish availability. Second, the recessive interactant had already given his/her commitment to further interaction. Third, the interactants were already in a state of open talk.

The combined use of the two rules of dominant interactant talking first and dominant interactant supplying the first topic provides for a large amount of control in the management of the interaction. The asymmetry in the opening statements affects how those statements are linked with the following statements.

Rule 3. The dominant interactant asks questions; the recessive interactant answers questions.

Approximately two thirds of the utterances were QA interchanges and one third were assertion interchanges.

Questions not only structured the episodes, they also served to introduce topics.

> Rule 4. When in a question the dominant interactant asks about a topic X the recessive interactant is obliged to imply topic X.

This rule was identified by Litton-Hawes (1976) in relation to doctors and patients in medical interviews. She found additionally that doctors did not need to abide by this rule and could defer answering on a topic implied by the patient. This however, did not occur in the present study.

Physicians and nurses have the right to present topics related to the patient's health state and the patient has the obligation to provide the information. Topics related to the physician's health state or the nurse's health state are not appropriate topics. The appropriate topic is the basis for the next rule.

> Rule 5. Topics in dominant-recessive interactions have to do with personal information regarding the recessive interactant.

Episodes are managed and topics are presented using predominantly a question/answer format. The following three rules demonstrate variations of question use in dominant-recessive interactions.

> Rule 6. When the recessive interactant has answered a question, the dominant interactant can then ask the same or similar question.

This rule is illustrated in the following examples.

(4)	MDS 1	We might even be able to engineer taking you home Christmas in the helicopter would you like that?, land at your farm?
	PT 2	°(Yeah)
	MDS 1	Hum?, as a special treat?...if you don't wanna just speak up we won't do it if you don't wanna
	PT 2	°(That'd be alright)
	MDS 1	Would you like that?
	PT 2	Yeah
(5)	RN 24	Did you see? some films? today
	PT 5	Nope
	RN 24	You didn't?
	PT 5	Hunc uh they never did come
	RN 24	They did?n't did they instruct you on anything? about, going to surgery you know
	PT 5	One of the nurses come up and was talkin to us

The second and third questions on the same topic serve to get more information from the patient. They also serve to question if the patient is sure of what he/she is saying. This also occurs in a more abbrieviated form but the result is the same: the patient must repeat his/her original answer:

(6)	MDS 1	I'm gonna stick you up in a chair how's? that?
	PT 2	°(O:K:)
	MDS 1	Uhm?
	PT 2	°(O:K:)
	MDS 1	OK?

(7) (Referring to the TV monitor in patient's room)

MDS 4 What's this? uh new kinda bug?

PT 6 Oh no this is tel:evised for some reason

MDS 4 Huh-?

PT 6 This is tel:evised

MDS 4 Televising you?

PT 6 Yeah

(8) RN 16 How do you feel?

PT 4 °(OK)

RN 16 OK?

PT 4 Um hum

Goffman (1976) speaks of these replies as rerun signals. The obvious function of an apparent 'unhearing' or misunderstanding can be a resource for saying one thing while meaning another. Goffman (1976) states:

> For to ask for a rerun can be to admit that one has not been considerate enough to listen or that one is insufficiently knowledgeable to understand the speaker's utterance or that the speaker himself may not know how to express himself clearly.... (p. 273)

Several reasons have been suggested for this practice. It may be that repeating is habitual and is learned in the education process or that the doctor or nurse was not listening to the previous answer (Litton-Hawes, 1976). It may be an attempt to structure the topic in the way that has meaning for the questioner (Coulthard and Ashby, 1975). Labov and Fanshel (1977) state that a repeated request is a challenge to the other's competence in role performance.

Whatever the reason for the repeat question it serves to disconfirm or not accept the first answer of the patient in and of itself. Furthermore, it requires the patient to repeat his/her answers to the questions. Another variation in the QA structure follows the next rule.

Rule 7. The dominant interactant may ask a question and without waiting for a reply may ask a second question.

(9)	MDS 1	How often? do you get these on your legs changed
	MDS 1	Have you been getting them changed very often?
	PT 2	Yeah they've been changed
(10)	RN 16	Um? do you have any questions? before I go?
	RN 16	What about the family? it's kinda ( ) to talk with everybody in here
	PT 5	Yeah, um, she said that I'd probly be down there for awhile you kno:w before they put me ta slee:p

Two questions in a row provide for "the rather enforced option of deciding which to answer" (Goffman, 1976, p. 287). The second question, however, often delimits the particular aspect of the topic presented in the first question to be addressed. It provides further topic direction for the recessive interactant.

Another exception to the usual two pair parts of an adjacency pair was the frequent occurrence of a three turn sequence. This sequence occurred with the addition of an

evaluation by the dominant interactant to the usual QA sequence.

Rule 8. A dominant interactant may verbally evaluate in the next turn the answer or response of the recessive interactant.

(11)	RN 16	So she like she talked to you pretty much what was going on an stuff
	PT 5	Yes ma'm
	RN 16	OK very good
(12)	Res	Can you wiggle your toes? like this
	PT 2	I can't straighten my foot: out?
	MDS 1	No you got it very straight you can't bend it is what you can't do, Push
	MDS 1	Good now lift this back up toward your head, back up like that

The dominant's reply serves to evaluate - to confirm, disconfirm or revise - the answer given by the recessive interactant. This operation assumes that it is the right of the dominant interactant to evaluate the response of the recessive interactant. Goffman (1976) notes the inappropriateness of the reversal of speakers in this operation; it is not the right of the recessive interactant to verbally evaluate the response of the dominant interactant. In one instance where the patient did evaluate the physician, he was interrupted when that evaluation was heard by the physician.

Rule 9. The dominant interactant proposes membership categories which are accepted by the recessive interactant.

Specifying a membership category is an operation used to label another person. Sacks (1972) describes the membership category "baby" as belonging to two membership category devices, "family" and "stage of Life". In the following utterance the physician introduces a nurse to a patient:

(13) MDS 1 Do you know who that is standin at the door thats Miss G. she's the boss of ya up here

The specification "boss" is a satisfactory reference to the membership categorization device - boss and subordinate. By categorizing the nurse as the boss, the physician has categorized the patient as the subordinate. The same operation occurs when the dominant person refers to the recessive as big boy or girl:

(14) MDS 1 PT 2 Got a little bit more skin grafting to do big boy

(15) RN 24 PT 4 That's a girl

Although the person referred to as "big boy" was sixteen years old, the person referred to as "girl" was a mature woman. In no instance did the recessive interactant deny, challenge or attempt to revise the categorization by the dominant interactant. The definition of the recessive's position was offered by the dominant interactant and accepted by the recessive interactant.

Dominant interactants can further suggest a membership category by suggesting a category-bound activity of the recessive interactant that is usually associated with a category.

(16)	MDS 1	Here's a playboy ((hands patient comic book)) do you wanna read? I'll putcha back...want the footstool? ...°(OK)
(17)	MS PT 2	You and I are goin to be playin together everyday for awhile, OK?
(18)	RN 5	O?kie dokie so I'll see ya this afternoon
	PT 5	Alrightie

Reading comic books, playing, and adding the suffix "ie" to words are activities bound to the category of child in the categorization device "stage of life". The category bound activity of reading a comic book was further emphasized by calling the comic book a Playboy, a magazine for adults. The strength of the suggestion of a category can be seen in the response of the patient in the last example. Prior to this interchange, words with the "ie" suffix were not used. The nurse used language as if she were addressing a child; the patient responded with the language of a child.

The dominant interactant frequently made statements which served to manage the pacing or timing of an episode. These statements, which Goffman (1976) calls bracket markers, helped with the cadence of activity. Statements like 'OK', 'now then' and 'well' mark the end of an episode phase or the beginning of another. These statements conform to the following rule.

> Rule 10. The dominant interactant manages the timing of the episode by using bracket markers.

The following examples illustrate the use of this rule.

(19)	MD 1	Uh I'd say in about another week or so
	MD 1	Now lets look at your ear S.
	PT 2	Its so:re
(20)	RN 16	This bothering you at all?
	PT 4	Hum ((shakes head))
	RN 16	OK can I see in your mou:th again?
	RN 16	OK let me give you the nur:se's call light

Dominant interactants use bracket markers to delimit boundaries in the episode. They were employed to voice the fact that a task has terminated or is about to begin. Bracket markers are asymmetrically used in the interactions. They are a resource that the dominant interactants use to manage the timing and progression of the interaction.

Rule 11. The recessive interactant uses a more formal term of address than the dominant interactant.

The patient's first name was used by the physician in all cases of address; in no instance was the physician's first name used by the patient. Nurses used either the first name or last name of the patient; patients did not address nurses by name.

Forms of address in this study were consistent with Ervin-Tripp's (1972) analysis of American forms of address. Friends or colleagues and persons of lower rank or lesser age are addressed by first names. Occupational titles are accorded people in certain statuses such as "Judge", "Doctor" or "Professor".

Becuase the title "nurse" is not used alone nor in conjunction with the last name, nurses were not called by name. This difference in title reflects the relative difference in status of doctor and nurse. This differential status may also account for the nurses' use of both forms of address - the patient's first name or the patient's last name. Further, the form of address in nurse-patient dyads reflects the lesser amount of status difference between interactants as compared to the physician-patient dyads. The influence of the interactants' age was also evident in the forms of address. Physicians, in general, were older than the male patients however, the women patients were older than the nurses. Forms of address in nurse-patient interactions demonstrated more status ambiguity and flexibility than those in the physician-patient interactions.

Patterns of interruption in this study varied from the normative model presented by Sacks et al. (1974) for conversation according to the following rule:

> Rule 12. The dominant interactant may interrupt the recessive interactant's talk before a transition-relevance place occurs.

A transition-relevance place is a possible completion point. The following examples illustrate this rule.

(21)

PT 2	°(OK) I's hopin I'd be °(home by Christmas)	
MDS 1	Pardon?	
PT 2	I's hopin I'd	get home
MDS 1	and sisters	You got eight? brothers

(22) PT 4 No I think I'll just, I'll just get [my rest

RN 16 [I've got some beds next door if you get some time...you can come help? me

(23) PT 6 Tell me one other thing...you seem to have all the answers, what gives me so much trouble with my testicles

MDS 5 Have I seen what?

PT 6 You seem to have all [the

MDS 5 [I don't know what kind of what kind of trouble have you got in your testicles

In two of the examples, the interruption occured after an 'un hearing'. The interruption occured when the hearing was comprehended regardless of where the recessive interactant was in the performance of the repeat. The last example also demonstrates what happens when the recessive interactant breaks the previous rule on evaluation.

The previous discussion contained rules that govern the ongoing conversational activity of dominant-recessive relationships. The last rule addresses how the conversational activity comes to a close.

A widely operative form of terminal exchange is the adjacency pair composed of conventional parts, e.g., an exchange of goodbyes. This form is the institutionalized form for closing ongoing conversational activity. The speaker of the first pair part proposes a close. The speaker of the second pair part demonstrates by a response that he/she understands what the first speaker is saying

and is willing to go along with it. In this study the dominant interactant produced the first pair part and the recessive interactant produced the second pair part. The following rule governs the closing of episodes.

Rule 13. The dominant interactant initiates the closing of the episode.

Examples of this rule are listed.

(24)	RN 24	OK thank you
	PT 5	Um hum
		((Nurse exits))
(25)	MDS 5	I'll be back to see ya uh little bit later
	PT 6	OK
		((Physician exits))
(26)	RN 16	So I'll (go out) and be back in a minute
	PT 4	OK
		((Nurse exits))

In all cases when there was a typical ritual closing it was intitiated by the dominant interactant. The recessive interactants initiated no closings. If the dominant interactant did not initiate a closing, it did not occur. Frequently, in its place was the reference to some type of activity by the dominant interactant:

(27)	MDS 1	Its about lunch time
	PT 2	Uh ((groan))
		((Physician exits))

(28) MDS 1 I'll talk to your parents S.

((Physician exits))

In these examples there was no conversational closing. The open state of talk was interrupted when one interactant left the room. This apparent lack of a closing can be understood if the patient is assumed to remain in an open state of talk as discussed under interaction openings. In this case a closing is not needed and is not supplied by either interactant.

Significance of Findings

The rules identified in this study demonstrate the procedures interactants use as resources in talk to enact their different statuses in the relationship. The dominant interactant controls the interaction timing by starting, pacing and stopping the episodes. Control of space is demonstrated when the dominant interactant may enter the recessive interactant's territory implying more personal address, a state of open talk and more personal information about the recessive interactant.

This study makes explicit the subtle and taken-for-granted operations so they may be examined by the interactants and health professionals. The validity of this study rests on your recognition of these operations in everyday conversations. We all know the rules but where are they written down for novices or foreigners to our speaking communities to use? These operations need to be

examined as to how they contribute to the individual's health, adaptation to the environment and greater understanding of one's self through relationships with others. The patient's own dignity and ability to regulate and control his/her own time and space must be preserved and potentiated through the therapeutic process. This study demonstrates that patients do not control their own time and space in interactions with physicians and nurses.

This study contributes to the growing body of knowledge of how everyday conversation is structured. Along with other rules for interaction, these rules may serve as a foundation for a theory of communication. This knowledge is necessary in understanding the growth and development of individuals and in utilizing the nursing process.

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